**Department of Social Services**
Delfino E. Neira, Director

# IHSS Recipient & Care Provider Request Form

Please complete the information below. If you need to report a new address and/or phone number, please submit the Address/Phone Number Change (SOC 840) form. If this form is not completed correctly, or we are unable to read the information provided, there could be a delay or we may not be able to process your request.

Your Name: _____ SSN: _____

Phone Number: _____ DOB: _____

**Please fill out the section that applies to your request:**

## I would like to order Replacement Timesheets

Provider Name: _____ Recipient Name: _____

Date Range(s): _____ To: _____ Recipient Case Number: _____

_____ To: _____

## I would like to Terminate a Provider from Employment

Provider Name: _____ Last Day Worked: _____

Number of Hours Worked in the Month: _____

Recipient Name: _____ Recipient Case No.: _____

## I would like to Reinstate / Rehire a Provider

Provider Name: _____ Rehire Date: _____

Hours: _____

Recipient Name: _____ Recipient Case No: _____

**Your Signature:** _____ **Date:** _____

## Contact Us:

Return form to:
IHSS – Public Authority
P.O. Box 1912, Fresno, California 93718-1912
Phone: (559) 600-6666 ≈ FAX: (559) 600-7762